GENERAL NOTICE OF ACTION

KIM-105 09/92

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE
*An Equal Opportunity Employer M/F/H

DATE

CASE NUMBER

CASELOAD CODE

KAMES-TL-4

IF ANY OF THE AMOUNTS LISTED BELOW ARE WRONG OR CHANGE, YOU SHALL REPORT IT TO YOUR WORKER WITHIN 10 DAYS. PLEASE SEE THE BACK OF THIS LETTER FOR IMPORTANT INFORMATION ABOUT CHANGES YOU SHALL REPORT IF YOU RECEIVE ASSISTANCE AND INFORMATION ABOUT REQUESTING A HEARING IF YOU ARE DISSATISFIED WITH ANY ACTION TAKEN ON YOUR CASE.

IF YOU WANT LEGAL HELP OR ADVICE, CALL YOUR ATTORNEY OR YOUR LOCAL LEGAL AID OFFICE AT:

WORKER'S NAME

ADDRESS

PHONE NUMBER

CITY. STATE, ZIP

CLIENT NAME

CASE NUMBER

YOUR RIGHTS

The Cabinet for Human Resources administers the Food Stamp, Aid to Families with Dependent Children and Medical Assistance Programs in accordance with State and Federal laws and regulations. We are required to take prompt action whenever we are informed of a change affecting eligibility or amount of assistance of any recipient and to give advance notice to the recipient of any action to be taken.

You have the right:

1. To discuss your situation in detail with your worker at the Department for Social Insurance.
2. To present any information you have *to* show the proposed action should not be taken.
3. To receive fair and impartial treatment regardless of age, sex, race, religious beliefs, political affiliation, national origin or handicap.

FROM THE DATE OF THIS NOTICE, YOU HAVE 40 DAYS TO REQUEST A HEARING ON PROPOSED AFDC OR MEDICAL ASSISTANCE CHANGES AND 30 DAYS FOR COMPLETED AFDC OR MEDICAL ACTIONS AND 90 DAYS TO REQUEST A HEARING ONFOOD STAMP ACTIONS.

HEARING PROCESS

An impartial hearing officer shall conduct the hearing. You may tell your story in your own way. You may be represented by an authorized representative, such as legal counsel, relative, friend, or other spokesman, or you may represent yourself. You may bring witnesses and documents with you to the hearing to help you establish facts. The hearing shall be orderly but informal. You or your representative shall be permitted to hear all evidence and examine all documents and records used at the hearing. You shall be informed of your right for further appeal. .

You may request a fair hearing by completing and returning this section to your worker, calling your worker by telephone or writing the Department of Social Insurance at 275 E. Main Street, Frankfort, Kentucky 4062 1.

( ) I wish to request a fair hearing because _____

_____

( ) I do not wish my benefits continued at the present rate pending the hearing results.

I understand that if my benefits are continued, my household shall owe the value of extra benefits received if the hearing decision is not in my favor.

CLIENT'S SIGNATURE _____ DATE _____ DATE RECEIVED _-

PENALTIES

If you purposely hold back information or fail to report changes within 10 days you may be barred from program participation and/or subject to prosecution for fraud.

Any changes in the following must be reported within 10 days of the time you learn of them:

1. Family income (amount and source) 2. Household members 3. Your address 4. Employment 5. Dependent care expenses 6. Sale of property or other increase in resources 7. School attendance for yourself

Food Stamp recipients must also report: 1. Number of vehicles 2. Shelter, utility or medical costs 3. Child over 16.

AFDC and Medicaid recipients must also report: 1. School attendance for yourself or child over 6 2. Discharge of someone in long term care 3. Return of parent to the home 4. Number of vehicles

You may report changes by filling out the lines below and taking or mailing to your worker or you may report changes by phone.

I wish to report the following changes: _____ _____

_____ This change is for the month(s) of _____

YOUR MEDICAL CARD

Any person whose name is shown on the medical card may receive needed medical services. However you must never permit anyone not named on the card to use it. If you receive emergency medical care before you receive your Medical Assistance ID card, you must present the card as soon as received to the provider of the medical services. If you or any member of your case is pregnant, the pregnant individual may continue to receive medical assistance.

LET US HELP YOU KEEP YOUR FAMILY HEALTHY

You are invited to get a free health and dental check-up for your children and you, if you are under 21 years of age. The health check-up includes: eye and hearing test; a test for kidney problems, TB, low blood, growth and development: nutrition and general health will also be checked; and immunizations (shots) will be given if needed. If any problems are found during the check-up, your children and you (if you are under 21) will receive help in getting treatment for these problems. Contact your local health department for assistance in making an appointment for the check-up and in arranging transportation.

MA-105
(R. 7/92)

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

FMTL-196

NOTICE OF ELIGIBILITY OR INELIGIBILITY

This is to inform you that we have reviewed your circumstances and have found that you live at the address below. The following decision(s) have been made on your case(s). ONLY THE BLOCKS CHECKED APPLY TO YOU. Please see the back of this letter for important information about reporting changes requesting a fair hearing if you are dissatisfied with any action taken on your case. If you want to request a fair hearing, contact your worker by _____.

Case No. _____

Date _____

[ ]

[ ]

[ ]1. Your [ ]STATE SUPPLEMENTATION PAYMENT [ ]MEDICAL ASSISTANCE [ ]QUALIFIED MEDICARE BENEFICIARIES (QKB) BENEFITS [ ]PAYMENT FOR LONG TERM CARE has been or will be [ ]Denied [ ]Discontinued effective _____ in accordance with Manual Section(s) _____ because _____

[ ]2. Your benefits are [ ]STATE SUPPLEMENTATION PAYMENT of $_____ effective _____ [ ]MEDICAL ASSISTANCE effective _____. [ ]QMB BENEFITS effective _____ You must pay $_____ per month toward your care in a Long Term Care facility, Home and Community Based Services, Hospice or Alternate Intermediate Services/Mental Retardation Project effective _____. The following persons are included in your case _____

[ ]3. Your benefits shown in number 2 decreased according to Manual Section(s) because _____

[ ]4. Your benefits shown in number 2 increased because _____

[ ]5. We are considering the following income in your case. $_____ Gross Earned and $_____ Gross Unearned.

[ ]6. We are considering the following deductions in your case.

$_____ Work Expenses, $_____ Dependent Care, $_____ Medical Expenses, $_____ Conserved for Dependents, $_____ Community Spouse Income Allowance, $_____ Family Income Allowance, $_____ SKI, and $_____ Personal Needs Allowance.

[ ]7. Other _____

IF YOU OR ANY MEMBER OF YOUR CASE IS PREGNANT, THE PREGNANT INDIVIDUAL HAY BE ELIGIBLE TO CONTINUE TO RECEIVE KEDICAL ASSISTANCE.

THE ABOVE ACTION IS BEING TAKEN IN ACCORDANCE WITH THE STATE REGULATIONS AT 907 KAR 1:004 OR 1:011 OR KAR 904 2:015, 2:040 OR 2:046..

IF ANY OF THE AMOUNTS LISTED ABOVE ARE WRONG OR CHANGE, REPORT IT TO YOUR WORKER WITHIN 10 DAYS. PLEASE SEE THE BACK OF THIS LETTER FOR IMPORTANT INFORMATION AND TO REPORT CHANGES OR REQUEST A BEARING.

IF YOU WANT LEGAL HELP OR ADVICE, CONTACT YOUR ATTORNEY OR LOCAL LEGAL AID OFFICE AT _____

Worker _____ Address _____ Phone _____

You can fill out this portion of the form to report a change to your worker or to request a hearing if you are dissatisfied with the decision on your case. An addressed envelope is included if you wish to mail this letter.

[ ] I wish to report the following changes: _____

_____

_____

[ ] This change is for the month(s) of: _____

[ ] I wish to request a Fair Rearing because: _____

_____

Client's Signature _____ Date _____ Date Received _____

REPORTING CHANGES

Report the following changes within 10 days of the time you learn of them:

1. Family income (amount and source)
2. Household members
3. Your address
4. Employment
5. Number of vehicles.
6. Sale of property or other increase in resources
7. Marital status
8. School attendance of yourself or child over 16
9. Dependent care expenses
10. Return of parent to the home
11. Discharge of someone in Long Term Care.

If for some reason you cannot mail this form, you may report the changes by calling your worker at the number on the front this form. Failure to report changes within 10 days, or to give complete and true information, may make you subject to prosecution for fraud.

YOUR MEDICAL CARD

Any person whose name is shown on the medical card may receive needed medical services. However, never permit anyone not named on the card to use it. If you receive emergency medical care before you receive your Medical Assistance ID Card, present the card as soon as received to tne provider of the medical services.

LET US HELP YOU KEEP YOUR FAMILY HEALTHY

You are invited to get a free health and dental check-up for your children and you, if you are under 21 years of age. The health check-up includes: eye and hearing test; a test for kidney problems, TB, low blood, growth and development; nutrition and general health will also be checked; and immunizations (shots) will be given if needed. If any problems are found during the check-up, you (if you are under 21) and your children will receive help in getting treatment for these problems. Contact your worker for assistance in making an appointment for the check-up and in arranging transportation.

HEARING PROCESS

You have the right to receive *fair* and impartial treatment from your worker regardless of your age, sex, race, religious beliefs, political affiliation, national origin, or handicap.

-If this form is providing notice of an action to be taken in your money payment or medical assistance case, you have the right to request a fair hearing in accordance with 904 KAR 2:055 within 40 days of the date of this notice. If you request a hearing within 10 days of the date on the reverse side of this notice, you may request that your assistance continue unchanged until a hearing decision is reached.

-If this form is providing notice of an action which has been taken on your money payment or medical assistance case, you have the right to request a fair hearing in accordance with 904 KAR 2:055 within 30 days. YOU may request a fair hearing by calling or writing your worker, or you may write to the Department for Social Insurance, Division of Administrative Review, 275 E. Main St., Frankfort, KY 40621.

-If you request a hearing on your benefits and the hearing is not ruled in your favor, your household may owe us the value of the extra benefits you received if you choose to continue receiving benefits at the same level pending the hearing.